Health Care Delivery System Workgroup:
Report to the Health Care Reform Coordinating Council

October 31, 2010

Introduction

The Co-Chairs of the Health Care Delivery System Workgroup hereby submit this report of the workgroup's efforts to the Health Care Reform Coordinating Council (HCRCC).

The workgroup sought input from the public to guide Maryland's implementation of the Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), commonly referred to as federal health reform. A discussion document was created to request public comments on the following issues: primary care reimbursement and access; patient-centered medical homes (PCMHs); payment reform; electronic health records/health information technology; evidence-based practices; behavioral health; controlling health care costs; regulated insurance products; health care professional schools; and grants, demonstrations, and pilot programs in Maryland. Individuals were also encouraged to provide comments on other topics if they wished.

Throughout the workgroup's activities, which included four meetings (held on August 25, September 24, October 7, and October 25), these issues were refined and additional issues emerged.

The workgroup focused its attention on the specific elements of its charge, based on both the Interim Report submitted to Governor O'Malley on July 26, 2010, and on the letter of direction provided by HCRCC Co-Chairs DHMH Secretary Colmers and Lt. Governor Brown.

This report summarizes the public input that was received. It identifies areas where common themes and suggestions—as well as differences of opinion—emerged.

As the workgroup's efforts proceeded, it became clear that no decisions are required in the next 12 months. Yet, even if certain issues do not require immediate decisions by policymakers, ongoing work must continue to be pursued in order to bend the cost curve; promote quality, access, and affordability; build collaborative models across providers, insurance carriers, employers, and public sector payers; and develop innovative models in Maryland.

Thus, the Co-Chairs present this report to the HCRCC with a concise statement on behalf of the individuals who offered public input: ***It is imperative that Maryland continue to work on these issues in 2011 and beyond to foster innovation and make a collective commitment to work toward cost-effective health care that delivers quality and access.***

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Shared Perspectives

In several areas, the majority of contributors shared a similar perspective, and common themes and recommendations emerged. Contributors generally provided the following suggestions and recommendations:

- Medicare and Medicaid provider reimbursement levels must be adequate to provide access, and should be increased, if possible.
- Provider reimbursement rates should include financing to support the costs of case management and care coordination.
- In order to effectively launch the PCMH initiative, payment rates should cover the start-up (and ongoing) costs related to electronic medical records, expanded office hours, development of care plans, medication management, and other activities.
- PCMHs should have a strong focus on patients with multiple chronic conditions.
- Bundled payments must be allocated fairly among providers, including both community-based and hospital-based providers.
- Because electronic health records and health information technology systems are very expensive, the state should provide funding for these.
- Evidence-based practices can be promoted through the use of health information technology.
- The public mental health system should receive more funding and behavioral health should be incorporated into medical homes.
- Maryland should promote the establishment of cultural and linguistic competency programs in health care systems and provider settings, such as organizational cultural competency assessments, implementation of linguistic service standards, and training of health care providers and support staff.

The majority of the themes and recommendations pertain to seeking funding for innovations and reforms, such as electronic health records systems, expansions in access, payment reforms, and the costs associated with PCMHs. Other concepts—such as the release of public information regarding insurance rate reviews and payment reform policies—require Maryland to change or implement new state policies.

Primary Care: Provider Reimbursement and Access

A primary care provider is a health care provider located in the community who serves as the first point of contact when an individual is in need of non-emergent medical care. Primary care providers are responsible for patients with a broad range of health issues, including patients who need assistance in managing a chronic illness.

A common theme among public comments was the need to address the shortage in the primary care workforce. Contributors said that, due to low provider reimbursement rates, Medicaid beneficiaries are finding it increasingly difficult to locate private providers willing to care for them. The contributors said that this causes unnecessary emergency room visits and expensive hospitalizations. These comments emphasized the fact that primary care providers who serve Medicaid beneficiaries face severe financial stress. Many contributors stressed that the primary care shortage will further reduce access to health care after the ACA expands health care coverage to more individuals in 2014.

One contributor said that urgent care clinics are available to provide after-hour and urgent services when patients have difficulty getting into their primary care providers for an urgent appointment, and that urgent care clinics are very cost effective relative to hospital emergency rooms. This contributor suggested that the state and payers better incorporate urgent care clinics. However, another contributor said that supporting urgent care clinics could be contradictory to moving toward a PCMH model; episodic urgent care services from different providers might undermine a patient's medical home.

A number of contributors suggested the following to address primary care reimbursement and access issues:

- Increase Medicare and Medicaid reimbursement levels
- Stabilize Medicaid funding
- Have reimbursements cover the costs of case management and care coordination
- Use funds gained from the decrease in uncompensated care costs to pay primary care providers
- Compensate nurse practitioners at the same rates as physicians for the same services
- Support funding for primary care residencies in rural areas
- Establish nurse-managed health centers in areas with high concentrations of vulnerable populations, such as family and juvenile courts and low-income housing sites
- Develop a Primary Care Access Plan that is updated regularly and identifies the populations in need of services, the resources to meet the needs of patients, and the resources needed to improve primary care access

Patient-Centered Medical Home

A patient-centered medical home (PCMH) model can help bend the cost curve. This model offers ongoing, complete, and coordinated care to patients. Maryland has recognized the benefits of PCMHs and is beginning its own medical home pilot.

Most comments were very positive and supportive of PCMHs. Many agreed that PCMHs should help control costs and increase access to care, quality, and efficiency. Some mentioned that CareFirst's primary care medical home is a good model to follow. Others expressed concerns that CareFirst's model might be problematic because it excludes nurse practitioners from leading a PCMH and because operationally it is hard to reconcile with the multi-payer model (e.g., the locus of care coordination in the multi-payer model resides with the provider, whereas the locus of this function in the CareFirst model resides with CareFirst).

However, some comments raised concern about the use of PCMHs. Some were worried that PCMHs will be expected to provide a fast fix to the health care delivery system challenges, even though these models are largely untested and many unanswered questions remain, including operational ones. Another concern was that the state's PCMH model is focused on large medical practices, although much of the primary care workforce in the state works in groups of fewer than five providers. Contributors said that if small group practices formed joint ventures in order to participate in the state's PCMH model, then these joint ventures might themselves raise legal and operational problems about HIPAA (sharing protected health information), billing, user control, and medical records, for example. To make the PCMH model available to the vast number of small primary care practices around the state, these issues would need to be addressed. Marketing and enrolling patients into a PCMH was another topic of concern; primary care providers do not have the time or the resources to be responsible for this aspect of PCMHs.

Contributors suggested that for PCMHs to be successful, they would need these components:

- In addition to a leading physician or nurse practitioner, a PCMH would need a support team of pharmacists, dentists, social workers, nurses, case managers, and other health workers to achieve the best patient outcomes
- The reimbursement rates to create PCMHs would need to cover upfront and ongoing costs associated with electronic medical records, expanded office hours, development of care plans, medication management, and other activities
- PCMHs would need to create a strong focus on patients with multiple chronic conditions
- PCMHs would need to coordinate and/or integrate treatment for behavioral health needs and meet SAMHSA's "bi-directional" model of PCMH
- Culturally and linguistically appropriate services, as well as transportation services, should be addressed

Payment Reform

In the United States, health care providers are paid mainly on the amount of services they deliver, not on the quality of the services or their role in improving health. Also, primary care and preventive services are reimbursed at low levels (relative to specialty and inpatient care) even though they provide much value. To amend this, payment methods could be changed to encourage highly effective care that advances patients' health, promotes care management and prevention, and creates efficiency in the delivery system.

Payment reform—specifically bundled payments and accountable care organizations (ACOs)—was a common topic in many comments.

Bundled Payments

Contributors were worried that a bundled payment system would place a high financial risk on providers. They also requested a clear definition of how a bundled payment would be divided fairly between a hospital and the hospital-based providers so that the quantity of hospital-based providers in the state would not decrease. One contributor suggested including a hospital-based physician as a Commissioner on the Health Services Cost Review Commission (HSCRC) to offer a provider perspective on bundled payments. In addition, community-based physicians and other providers also shared concerns about bundled payments and how they would be divided.

Regarding the use of bundled payments for readmissions, some contributors stated that it was important to remember that hospitals and providers cannot prevent all readmissions. Patients sometimes do not comply with post-discharge instructions, causing a readmission. Also, hospitals and providers should not be held responsible for operating in an area that lacks outpatient resources. A few contributors argued that, for a bundled payment method to be practical, it is essential for hospitals to be electronically connected to multiple providers, such as physicians, pharmacists, nurses, and other health workers in the community.

ACOs

Contributors said that reimbursement for ACOs should include funds for upfront costs to implement electronic health records, expand hours, teach patient education, and perform other activities. Also, it is important to determine and resolve any federal legal barriers that might impede the development of ACOs, such as federal anti-trust and anti-kickback laws. At the state level, it is necessary to determine what, if any, changes are needed to the HSCRC Medicare Waiver in order for the HSCRC to promote the creation of ACOs in Maryland.

Another contributor stressed that quality and outcomes measurement and data that are used to determine payments should be developed with the assistance of specialty-specific national and local medical societies and other professional societies. An additional comment suggested that Maryland create a plan in which hospitals receive a fixed (block) payment to cover their patients' chronic disease needs.

Electronic Health Records/Health Information Technology

Electronic health records (EHRs) and health information technology (health IT) are being pursued as ways to improve health care quality, streamline administrative processes, and reduce medical errors and expenditures.

Many contributors agreed that EHRs and health IT are important for helping the health care delivery system operate more efficiently while lowering costs. One contributor was afraid that, like PCMHs, EHRs and health IT might be considered unrealistically quick fixes to the rising cost of care, even though a more realistic assessment might be that these benefits will not be seen for several years. Also, this technology is extremely expensive, especially for small group practices. One contributor pointed out that a large health care system spent $100 million on this technology, while a small community hospital spent $40 million. The cost of launching this technology on a widespread basis would require public financing and public investments.

Other comments regarding EHRs and health IT included the following:

- Primary care providers should be eligible for incentive payments given through the Maryland Health Care Commission (MHCC) that promote the use of EHRs
- Health care professionals, such as nurse informaticists, should help implement EHRs and health IT into practices
- Hospitals should receive incentives for adopting technology that allows for patient monitoring to reduce readmissions and patient noncompliance
- Meaningful use compliance of EHRs is needed
- Data reporting requirements are very expensive
- Health care providers will need to be educated to use EHRs and health IT properly
- Health IT, such as telehealth devices, can be used to address the health care workforce shortages in rural and underserved areas
- MHCC should permit hospital-owned practices to receive incentive payments to adopt EHRs. These practices, when not "based" at hospitals, could receive funds within the intent of ARRA, which bars federal incentives only to hospital-based practices. Moreover, hospitals cannot easily finance the adoption of EHRs by hospital-owned practices without potential legal issues under Stark and related laws. Thus, one contributor urged MHCC to reconsider its policy regarding incentive payments to hospital-owned practices.

Evidence-Based Practices

The National Guideline Clearinghouse is a database of clinical practice guidelines for health providers. These guidelines have been created based on evidence-based practices. However, studies have demonstrated that some providers do not follow established clinical guidelines or use evidence-based practices.

There are several barriers to the adoption of evidence-based practices, including lack of knowledge, familiarity, or agreement with the guidelines; limited ability to apply guidelines; lack of description of the type of patients to which the guidelines apply; and ambiguity about the effects of guidelines on health outcomes. Also, a survey demonstrated that providers believe the value of a treatment option ultimately relies on the opinions of the patient and provider. In addition, limited funding to support evidence-based research prevents evidence from being discovered. Further, some providers believe evidence-based research is subjective because it can rely on qualitative evidence, such as experts' recommendations. Another barrier to the adoption of evidence-based practices is convenience. In a busy practice, it is difficult for providers to find time to search for a clinical guideline.[1]

The workgroup received comments regarding the promotion of evidence-based practices in order to avoid payments for procedures and treatments that are either not efficacious or not the most cost-effective option from among the treatment modalities that are equally safe and effective. One contributor said that evidence-based practices would be more readily accepted by providers if these practices were emphasized in the curriculum of providers' training programs.

Others said that health IT is essential to encouraging the use of evidence-based practices. Health IT can offer clinical guidance to all practitioners, including those who practice in rural areas where practitioners feel isolated from other providers and do not have the resources to discuss practice issues. Health IT would give providers the most current clinical treatment guidelines.

A few comments affirmed that Maryland should not duplicate the work that is being completed at the national level, but instead should set up a mechanism to disseminate evidence-based practices research. Also, the work of the Governor's Quality Council should be continued, safe harbor protections should be implemented for the use of evidence-based practices, and hospital-owned practices should be allowed to participate in EHR funding through HB 706.

[1] Mendelson, D., & Carino, T. V. (2005). Evidence-based medicine in the United States – de rigueur or dream deferred? *Health Affairs, 24*(1), 133-136.

Behavioral Health

Behavioral health is a critical part of health care and a person's overall wellbeing. Maryland's public mental health system serves about 117,000 adults and children, while the public substance abuse system assists nearly 35,000 individuals.

As the following comments indicate, the public mental health and behavioral health systems are in need of change:

- Better integration of somatic and behavioral health services would help bend the cost curve, as well as the "incidence" curve, through cost-effective early prevention and treatment.
- Support and funding for behavioral health PCMHs should be incorporated in the state's plans regarding PCMHs.
- Substance abuse services and the mental health system should be combined into a single system. If this were to occur, a contributor said that it would require a significant change in either the substance abuse or the mental health system.
- The standards of parity should be maintained in Maryland's new health care delivery system. This can impact whether the mental health and substance abuse treatment systems can be integrated.
- It is unclear if parity laws apply to a carved-out system. This should be determined before changes in the system are made.
- The state should include behavioral health providers in incentive payments for electronic health records.
- The state should include behavioral health in the health information exchange.
- The state should support the use of integrated dual-disorder treatment systems and integrated care best practices.
- The state should support efforts to reverse the workforce crisis in behavioral health and reduce turnover rates.
- The state should implement compliance monitoring for private behavioral health carriers to ensure the new parity requirements are honored.
- The state should provide funding for a more extensive array of services, such as home visits to recovering addicts.

Controlling Health Care Costs

Health care spending in the United States is of grave concern among policymakers around the country. In 2009, the United States spent approximately $2.5 trillion—or 17.3 percent of gross domestic product (GDP)—on health care. This figure is expected to increase to 19.6 percent of GDP by 2019.[2]

Contributors suggested the following ideas to address the cost drivers of the health care system.

Public Health

Evidence-based prevention activities can help circumvent premature mortality and be cost-saving and cost-effective. Bending the incidence curve (reducing the incidence of certain diseases, such as tobacco-related illnesses, through cost-effective public health interventions) can help bend the cost curve. Testimony presented literature showing that if a prevention program in Maryland focused on physical activity, diet, and smoking, then the return on investment for every dollar spent on the prevention program would equal $6.67 after 10 to 20 years. Contributors said that county health departments should be expanded to address population-based health issues, and the Healthiest Maryland Initiative should be strengthened. Also, Maryland should increase the focus on disease prevention in the transformation of the existing health system.

Childhood Obesity

One contributor indicated that Maryland should consider legislation that requires body mass index (BMI) screenings in schools. School-based clinics can enforce the screenings and follow up with parents to offer education and support about proper nutrition, exercise, and other factors that influence obesity. Another contributor voiced concern that schools without school-based clinics would not have the expertise to counsel students with high or low BMI screenings. This contributor said that BMI is a medical matter and school professionals may not communicate properly with students, which can be harmful if students have body image issues.

Community Health Workers

Community health workers can improve the health of patients at a low cost. These workers address the cultural, lifestyle, and environmental factors that influence health while allowing providers to concentrate on treating disease. Maryland should consider adopting payment mechanisms and policies that reward providers who use community health workers in their practice.

Tort Reform

Maryland should enact tort reform measures to reduce the costs of defensive medicine.

[2] Centers for Medicare and Medicaid Services. (2010). *National health expenditure projections 2009-2019, forecast summary*. Baltimore, MD. Retrieved September 14, 2010, from https://www.cms.gov/NationalHealthExpendData/Downloads/NHEProjections2009to2019.pdf

Pharmaceuticals

Buying power should be pooled in order for patients and payers to be able to afford expensive medications. Also, one contributor suggested a tax on pharmaceutical companies to encourage companies to lower costs.

Medicaid Coverage Rules

Review Medicaid coverage rules that prevent the delivery of cost-effective care.

Case Management

Similar to Maryland's Rare and Expensive Case Management program, case management should be expanded to additional medically complex and chronic conditions, which can help lower costs.

Reducing Unnecessary Care

Patient education that teaches patients how to weigh the benefits and burdens of certain treatments may help reduce unnecessary care. Also, a public education campaign about the nature and availability of hospice and palliative care and the difference between the two was suggested. One contributor was concerned that if added quality-adjusted life years (QALYs) were used to determine the value of a medical treatment, then it may cause unintentional discrimination against vulnerable populations who perceive their quality of life to be higher than QALYs estimate. Thus, this contributor suggested that the HCRCC consider rejecting the use of QALYs.

Home-Based Primary Care

Maryland should test a home-based primary care program, in which health care teams, directed by physicians or nurse practitioners, provide care in the patient's home and coordinate the patient's care across treatment levels. A contributor said that this type of program could improve outcomes and satisfaction for these patients, who typically have multiple chronic conditions. Another contributor said that home-based provider care, when coupled with technology, could help patients avoid unnecessary institutional placement in settings such as nursing facilities; this would be a cost-effective alternative.

Regulated Insurance Products

Employer-sponsored insurance is the primary source of health insurance in the United States, providing coverage to nearly 157 million nonelderly individuals. However, in recent years, companies have been struggling to offer health insurance coverage as insurance costs continue to escalate. From 2009 to 2010,[3] average annual premiums for single coverage employer-based health insurance increased 5 percent (from $4,824 to $5,049). Average annual premiums for family coverage increased 3 percent (from $13,375 in 2009 to $13,770 in 2010). Since 2000, average family coverage premiums have risen 114 percent. To cope with high insurance costs, employers have used strategies such as increasing cost sharing, eliminating benefits and the scope of coverage, and raising the amount employees pay for insurance.[4]

Public comments insisted that Maryland continue to ensure that insurance rate and premium increases are justified. Also, in order to reduce administrative costs, insurers should be encouraged to be more efficient when handling claims from hospitals, providers, and practices.

Other comments requested that Maryland provide more information to the public regarding premium rate reviews and insurance regulation.

One contributor suggested that Maryland encourage insurance companies to remove barriers that exclude nurse practitioners from insurance provider panels because nurse practitioners are often a more cost-effective alternative for delivering primary care. This contributor also stated that payment parity between physicians and nurse practitioners should be promoted.

[3] The 2009 survey was conducted January 2009 through May 2009. The 2010 survey was conducted January 2010 through May 2010.

[4] Kaiser Family Foundation/Health Research and Educational Trust. (2010). *Employer health benefits: 2010 summary of findings.* Washington, DC: The Henry J. Kaiser Family Foundation. Retrieved September 13, 2010, from http://ehbs.kff.org/

Health Care Professional Schools

Health care professional schools provide and train the future generation of health care workers. The following issues regarding health care professional schools were raised in the public comments.

Student Debt

Many health workers have high debt due to the costs of professional health schools. Unfortunately, state funding for scholarships and loan repayment programs is limited. More funding options for students will be necessary to have a diverse workforce and to encourage students to work in primary care and underserved areas after graduation.

Faculty Compensation

Salaries for faculty members who work in health care professional schools are often below salaries in the clinical field. In order to encourage faculty members to train and educate health workers, compensation must improve.

Interprofessional Education

To encourage clinicians from various health professions to work together, it is important to emphasize interprofessional teams during the education process. In these teams, each member uses his or her expertise and works with other members to achieve patient-centered goals.

Grants, Demonstration Projects, and Pilots for Maryland

The ACA and HCERA provide Maryland the option to apply for grants, demonstration projects, and pilots that are related to payment and delivery system reform.

Through public comments, Maryland was encouraged to pursue the following grants, demonstration projects, and pilots that were suggested by the Health Care Delivery System Workgroup:

- *Section 2706 – Pediatric Accountable Care Organization demonstration project:* Establishes a demonstration project that would allow qualified pediatric providers to be recognized and receive payments as ACOs under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.
- *Section 3022 – Medicare shared savings program:* Would reward ACOs that take responsibility for the costs and quality of care received by their patient panel over time. ACOs could include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality of care targets and reduce the costs of their patients relative to a spending benchmark would be rewarded with a share of the savings they achieve for the Medicare program. Section 10307 provides additional flexibility to the Secretary of the U.S. Department of Health and Human Services (HHS) to implement innovative payment models for participating ACOs, including models currently used in the private sector.
- *Section 2403 – Money Follows the Person Rebalancing Demonstration:* Extends the Money Follows the Person Rebalancing Demonstration through September 30, 2016, and changes the eligibility rules for individuals to participate in the demonstration project by requiring that they reside in an inpatient facility for no less than 90 consecutive days.
- *Section 2703 – State option to provide health homes for enrollees with chronic conditions:* Would provide states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.
- *Section 3502 – Grants or contracts to establish community health teams to support the patient-centered medical home:* Would create a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community-based, coordinated care. Section 10321 clarifies that nurse practitioners and other primary care providers could participate in community care teams.
- *Section 3504 – Design and implementation of regionalized systems for emergency care:* Would provide funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Would require the Secretary of HHS to support emergency medical research, including pediatric emergency medical research.

- *Section 5405 – Primary Care Extension Program:* Would create a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality (AHRQ) would award planning and program grants to state hubs, including, at a minimum, the state health department, state-level entities administering Medicare and Medicaid, and at least one health professions school. These state hubs may also include Quality Improvement Organizations, Area Health Education Centers, and other quality and training organizations.
- *Section 10202 – Incentives for states to offer home and community-based services as a long-term care alternative to nursing homes:* Would add a new policy that creates financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into home and community-based services (HCBS). Would provide Federal Medical Assistance Percentage (FMAP) increases to states to rebalance their spending between nursing homes and HCBS.

In addition to the above, contributors also suggested the following grants, demonstration projects, and pilots for Maryland:

- *Section 2401 – Community First-Choice Option:* Establishes an optional Medicaid benefit through which states could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation.
- *Section 2402b – Removal of barriers to providing home and community-based services:* Removes barriers to providing HCBS by giving states the option to provide more types of HCBS to individuals with higher levels of need through a state plan amendment (rather than through a waiver) and to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.
- *Section 4306 – Funding for childhood obesity demonstration project:* The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 included several provisions designed to improve the quality of care under Medicaid and CHIP. This law directed the Secretary of HHS to initiate a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. This section appropriates $25 million for the childhood obesity demonstration project and adjusts the demonstration time period to fiscal years 2010 through 2014.

One contributor suggested that Maryland fully fund the Older Adults Waiver and Living at Home Waiver. Other general ideas for pilots were suggested, such as a pilot examining:

- The re-direction of stable, older adult patients to sub-acute or nursing facilities instead of admission into acute care facilities
- Technologies that offer preventive care for chronic illnesses
- The effect of medical malpractice reform on total cost savings

- Wellness-, prevention-, and lifestyle-related programs for the state employee/retiree population

Conclusion

The Co-Chairs of the Health Care Delivery System Workgroup wish to thank everyone who tendered comments for their invaluable contributions to this process. They hope the HCRCC can utilize the perspectives presented in this document to begin to construct a health care delivery system that best serves the needs of Marylanders.

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